EXHIBIT 24

UNITED STATES DISTRICT COURT

DISTRICT OF MASSACHUSETTS

NO. 01CV12257-PBS

In re: PHARMACEUTICAL)
INDUSTRY AVERAGE WHOLESALE)
PRICE LITIGATION)
)
THIS DOCUMENT RELATES TO:)
ALL ACTIONS)

HIGHLY CONFIDENTIAL

VIDEOTAPED DEPOSITION OF SHEILA R. CIZAUSKAS

800 BOYLSTON STREET

BOSTON, MASSACHUSETTS

FRIDAY, 10 MARCH, 2006

9:38 AM

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Q. Do you have any understanding as to what the relationship is, if any, between ASP and AWP?
A. No.
Q. Do you understand those to be different numbers?
A. Yes.
Q. So, you understand that if we're talking about any given drug, the ASP will be an entirely different number from the AWP for that drug.
MR. COCO: Objection.
A. I don't know that to be true in every case or any case.
Q. Well, when you said earlier that you understood the ASP to be different from AWP, what did you mean?
A. I mean that it's a different frame of reference, but I don't know that the actual price is different in every case or any case or all cases.
Q. But you understand it's a different benchmark?
A. Yes.

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Q. Do you know whether BCBS of Massachusetts ever considered shifting to an ASP-based methodology with regards to drugs administered in physicians' offices?
A. I don't have any knowledge of decisions for physicians' offices.
Q. Are you aware of contemplation of shifting to an ASP-based methodology in any other circumstances?
A. It was offered as a potential methodology in the development of a hospital outpatient fee schedule.
Q. When you say it was offered, what do you mean by that?
A. When we decided to establish a fee schedule for drugs at the -- in the hospital outpatient setting, it was one methodology that was offered late in the -- in the process. We had already done a lot of work and came to a different methodology, but that had been offered as a suggestion late in the process.
Q. Now, when did BCBS of Massachusetts first set up a fee schedule for hospital outpatient department drugs?

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A. It was effective October 1st, 2005 for a small subset of hospitals.
Q. Prior to October 1st, 2005, how had BCBS of Massachusetts reimbursed hospital outpatient departments in relation to drugs administered to members?
A. As a percent of charges. It was paid on a percent-of-charges basis.
Q. Was the percent of charges static, or did it vary from contract to contract?
A. It was a negotiated percent by contract.
Q. So, prior to October 1st, 2005, all hospital outpatient departments were reimbursed in relation to drugs administered to members at a percentage of bill charge, but the percentage varied from contract to contract.
A. Correct.
Q. After October 1st, 2005, did some hospitals transition to the new fee schedule or all hospitals?

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A. Only the hospitals that were up for renewal at that point.
Q. Now, how many hospitals were up for renewal at that point?
A. I don't know exactly. Each year, generally, a third of our network is up for renewal.
Q. Is it contemplated that as more hospital outpatient department-related contracts come up for renewal BCBS will seek to transition them also from a percentage of charge-based methodology to the new fee schedule?
A. Yes.
Q. What is the methodology utilized in the new fee schedule in relation to reimbursing hospital outpatient departments for drugs administered to members?
A. It's a percent of AWP.
Q. What is the percent of AWP in question?
A. 95 percent.
Q. So, BCBS of Massachusetts has made a purposeful decision that it wants to transition

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hospital outpatient departments from a percent-of-charge basis -- in relation to drugs administered to members -- to an AWP-based methodology --

MR. COCO: Objection.

Q. -- is that correct?

A. It's a conscious decision to transition from percent of charge -- which is unpredictable and dependent upon the hospital's setting of their charges -- to a more predictable methodology that has -- that has an industry understanding or an industry standard.

Q. And that's AWP.

MR. COCO: Objection.

A. And that is -- that was the AWP fee schedule.

Q. When was the question of setting up a fee schedule for hospital outpatient departments first raised?

A. It was raised in maybe the winter of 2003.

Q. And who raised that topic for the first time?

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A. I don't know for the first time, but I raised the question of how much was -- how much of our hospital reimbursement was being paid at a percent of charges and asked to commission a group to look at how to update that to a -- to fee schedules where appropriate.

Q. Who did you raise this issue with?

A. My boss.

Q. And who was your boss at that time?

A. Deb Devaux and a group of leaders that -- well, she brought that to a group of other leaders in the organization, and a group was commissioned to study it.

Q. Now, the group of leaders that she took the proposal to -- took your proposal to -- does that group go by any particular name?

A. PFSW.

Q. That's the Provider Financial Strategy?

A. Provider Financial Strategy -- yeah. Yeah.

Q. So, you took the proposal to Deb Devaux; she took it to the Provider Financial Strategies Work Group, and what did they then do?

A. They agreed that it was something to study, and a -- and a team was commissioned, and through that team, a phased-in approach to a new outpatient fee schedule methodology was developed.

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Q. Now, who was on the team that was commissioned to study this issue by the Provider Financial Strategy Work Group?

A. I don't remember the people's names, but they represented cross-functional areas of the organization that included claims IT, finance, contracting -- the first phase of the team included someone from our pharmacy area and payment policies.

Q. Do you recall the names of any of the individuals who were on that committee?

A. Myself, Terrence Driscoll, who worked in finance at the time -- he has since transitioned to my team -- Tom Kowalski, Mark Pruesar, Carlene Fournier.

Q. I'm sorry. As you list these people --

A. Yeah.

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Q. -- could you also describe what of the -- which of the cross-functional areas you described earlier they come from?

A. Mark Pruesar came from actuarial. Tom Kowalski came from pharmacy. John Killion came from ancillary contracting. Some of these people came in and out of the team as necessary.

Q. Was Mr. Killion a consistent member of the team?

A. No, he was -- came to a few meetings.

Q. Anyone else that you recall?

A. Some of the people were on the phone, so I can't even picture their faces, but they were from the operational areas -- claims IT and payment policies.

Q. When was this -- well, withdraw that. You first raised the issue with Ms. Devaux in winter of 2003, right?

A. Yes.

Q. Okay. When did the provider -- and she then took it to the Provider Financial Strategies Work Group?

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A. It was different for each hospital.
Q. Were there circumstances in which payment on an AWP-based methodology would be more cost effective for Blue Cross Blue Shield of Massachusetts?
A. There were cases where the AWP methodology would pay less than the percent-of-charge methodology in isolation. So -- and then there were also cases where the AWP methodology would pay more than the percent-of-charges methodology.
Q. Would you have an understanding as to in what proportion of cases AWP would result in lower payment versus higher payment?
MR. COCO: Objection.
A. What percentage of cases? You mean hospitals?
Q. Uh-huh.
MR. COCO: Objection.
A. How many hospitals -- you're asking me how many hospitals resulted in --
Q. Well, let me -- let me rephrase the question. Was the analysis in relation to drugs

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specifically carried out on a hospital-by-hospital level or a drug-by-drug level?
A. Hospital-by-hospital level.
Q. Okay. So, for any given hospital, the analysis that was performed was to look at what drugs were being billed for, how much was being paid for them on a percent-of-charge basis, and how much would be paid on an AWP basis?
MR. COCO: Objection.
Q. Is that correct?
A. I'm not sure. If you could just say that again.
Q. Sure.
MR. MANGI: Would you mind rereading the question.
(Question read back.)
A. So, we looked at a hospital and all of the codes that would fall into an identifiable bucket of codes, how much was paid historically for that group of codes, and then we looked at how much would be paid if we paid 95 percent of AWP for that group of codes. And that number was provided to

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the contracting department and was part of the negotiation in the renewal.
Q. Did you find that for -- since the analysis was on a hospital-by-hospital basis, at specific hospitals, was there variation as to whether AWP-based billing for drugs, you know, would be higher than bill charges for some drugs and lower than bill charges for other drugs?
MR. COCO: Objection.
A. We didn't look at a drug-by-drug analysis. It was overall.
Q. Okay. So, on the basis of that overall analysis, was there any consistency as to whether AWP was higher or lower than bill charges for drugs?
A. Some hospitals --
MR. COCO: Objection.
A. -- the AWP methodology paid more, and some hospitals the AWP methodology paid less.
Q. Do you know what the relative proportion was of hospitals for which AWP resulted in higher payment versus lower payment?

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A. Fewer hospitals resulted in higher payment.
Q. So, for the majority of hospitals, based on the analysis that BCBS of Massachusetts carried out in late '04 and '05, moving to an AWP-based methodology to reimburse for drugs administered in office --
A. In hospital.
Q. -- in hospitals, would result in a net saving.
MR. COCO: Objection.
A. Not necessarily, and if I could just expand a little bit, the -- it was a component of the negotiation of the renewal. And so, ultimately, the renewals ended up with higher rates overall for the hospital than prior to the renewal.
Q. Well, I'd like to get to the negotiation a little later. For now I'm --
A. Uh-huh.
Q. -- focusing just on the analysis that was performed prior --
A. Uh-huh.

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Q. -- to the negotiation. I understood from your testimony earlier that the analysis only showed that -- and for the majority of hospitals studied --
A. Uh-huh.
Q. -- reimbursing at a percentage of AWP -- 95 percent of AWP -- would result in BCBS paying less than it had been paying under the percentage-of-bill-charge methodology.
MR. COCO: Objection.
Q. Is that correct?
A. The part that I'm struggling with is that it would have generated a payment of less to Blue Cross. What it generated was an analysis that showed one methodology having higher level of cost or payment -- if that were implemented -- than another methodology. But then, we need to go to the implementation, which --
Q. I understand that. I'm talking only about the analysis for the moment.
A. Uh-huh. Right.
Q. Not about what actually happened.

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A. So, it isn't -- I guess I'm struggling with the word "savings," because that suggests that there ended up being a savings.
Q. Let me try and rephrase it then without using that word.
A. Okay.
Q. All right. In late 2004 and early 2005, I understand from your testimony that BCBS of Massachusetts analyzed the amounts it was paying to -- it had paid historically to certain hospitals for drugs that they administered in their hospital outpatient departments, right?
A. (Nods.) Right.
Q. And those payment -- historic payments that were being studied were a percentage of the hospital's bill charges.
A. Correct.
Q. Okay. BCBS also then calculated what it would have paid if those payments had, instead, been paid on the basis of 95 percent of AWP.
A. Correct.
Q. And BCBS then compared those two numbers.

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A. Yes.
Q. Compared them to see whether -- if the payment had been at 95 percent of AWP, would it have permitted more or less than it actually did using a percentage of bill charge?
A. Correct.
Q. And as a result of that analysis, BCBS concluded that if it had made those payments based on 95 percent of AWP, for the majority of hospitals, it would have paid less in reimbursement than it actually did using the percentage-of-bill-charge methodology.
MR. COCO: Objection.
A. For the hospitals that were up for renewal, which was a subset of all of the hospitals, most of the hospitals, the AWP number was lower than the percent-of-charge numbers. But some hospitals, the AWP was higher than percent-of-charge number.
Q. But based on that analysis, BCBS then decided that it would seek to transition all hospitals to an AWP-based methodology.

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A. No.
MR. COCO: Objection.
Q. Okay. Was a decision made to only seek to transition those hospitals for which AWP resulted in a savings -- would result in a savings compared to bill charge?
MR. COCO: Objection.
A. No. You said that, based on the analysis, Blue Cross made the decision to transition to AWP, and that's not the case. The decision to transition to AWP was based on having a standard fee schedule. The analysis was intended to call to our attention what that impact would be on the hospital.
Q. I see. So, the analysis was one of the factors that BCBS looked at in considering whether or not to move all hospitals to an AWP-based methodology.
A. No.
MR. COCO: Objection.
Q. It wasn't one factor that was looked at.
A. No.

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A. That's a standard fee schedule. That is -- has been implemented consistently with the renewal hospitals.
Q. Am I correct in my understanding that BCBS is now seeking to transition all hospital outpatient departments to the new fee schedule?
A. As hospitals come up for renewal, it will be one of the components of the negotiation, and it's intended that they will be implemented on the new fee schedule.
Q. When was the -- I understand that the implementation of these -- of this change started in October of '05, but when was the final decision made by the Hospital Outpatient Department Fee Schedule Group to proceed with the transition?
MR. COCO: Objection.
A. Probably the spring of '05.
Q. So, between spring and October, the company was working on logistical issues associated with making the transition?
A. Negotiations generally start with hospitals in the spring and summer of the preceding

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-- of the year that the new rates go in place.
Q. What proportion of hospital outpatient departments have now been transitioned to the new AWP-based fee schedule?
A. I don't know exactly, but I -- it's between 25 and 30 percent of the hospitals.
Q. Have any hospitals thus far refused to make the transition?
A. No.
Q. How long is it anticipated that it'll take before all hospital outpatient departments have been successfully transitioned to the new AWP-based fee schedule?
A. Five years.
Q. So, BCBS of Massachusetts plans to continue working to transition all hospitals to an AWP-based fee schedule until that process is completed in approximately 2011?
A. The decision has been made for the renewals that are coming up for October of '06 to include the AWP fee schedule in those renewals.
Q. And it's anticipated that by 2011, the

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process will be complete and all hospital outpatient departments will have been transitioned to AWP-based fee schedules.
MR. COCO: Objection.
A. If we continue in this manner, yes. But there's been no decision that we wouldn't change to another methodology. It's been decided for the renewals in 10/1/06 to continue.
Q. Well, is there a -- when you said it's anticipated it'll will take five years to do that, is that a -- is that number -- how did you come up with that number?
A. I'm just thinking about how long -- how long we have with each contract. So, I'd say, actually, it was probably five years at the time we started this. Now it's probably four years. Our longest contract out there is a five-year contract, so that's what I'm thinking.
Q. So, the decision has been made on an ongoing basis to continue to transition hospitals to an AWP-based fee schedule for drugs administered in outpatient departments as the contracts come up

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for renewal, and based on the current rate of progress, if there's no change in approach, you anticipate that will take up until around 2011.
MR. COCO: Objection.
A. The decision has been made for the renewals that are coming due this year to include AWP fee schedule in those renewals. Each year the -- all of the components to the hospital contract are reviewed and decisions are made annually.
Q. Am I correct in understanding, though, that in -- when a decision was made to proceed with the transition, the decision was to try and proceed with the transition for all hospitals, but to stagger implementation as contracts came up for renewal?
MR. COCO: Objection.
A. The decision is made on an annual basis of how to handle the group of hospitals that are up for renewal. And that's -- so, at this point, we have the renewals that took place for 10/1/05, and now the renewals that are coming due for 10/1/06 that we include AWP.

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Q. So, in the spring of '05 -- withdraw that. Do I understand correctly that these contracts come up for renewal once a year?
A. There are multi -- they're multi-year contracts, so there are some contracts that come up for renewal each year. It's not the same contract each year.
Q. So, in the spring of 2005, a decision was made to implement the transition for all the contracts that were coming up for renewal later in '05.
A. Correct.
Q. And this year, in '06, a decision's been made to implement the transition to an AWP-based fee schedule for all contracts that are coming up for renewal in '06?
A. Correct.
MR. COCO: Objection.
Q. And similarly, the decision for '07 will be made in early '07.
A. Yes.
Q. Okay. When --

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MR. COCO: When you get to a good breaking point.
Q. When was the decision made regarding transitioning hospitals that are coming up for renewal in '06 to an AWP-based methodology?
MR. COCO: Objection.
A. When was the decision made for the '06 hospitals?
Q. Yeah.
A. It was made in conjunction with the overall hospital contracting plan, and I would say that that was made early in '06.
Q. In January or February of '06?
A. I can't put a particular date. There was -- there was no decision made to deviate from the prior years' implementation.
Q. Who made the decision regarding implementation of the transition to an AWP-based methodology for hospital outpatient departments in 2006?
MR. COCO: Objection.
A. There is no single person. It's sort of a

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consensus decision.
Q. Is the Hospital Outpatient Department Fee Schedule Group still in existence?
A. Yes.
Q. Is that the group which makes the decisions regarding transitioning hospitals to the new methodology?
A. No.
Q. Okay. Is that group tasked merely with the analytical and logistical work associated with making those changes?
A. Yes.
Q. So, who or which group is responsible for making the actual decision about transitions?
A. PFSW.
Q. So, in the spring of '05, when a decision was made to transition the contracts coming up for renewal in '05, that was a decision from the Provider Financial Strategies Group.
A. The Provider Financial Strategy Group would be made aware of the overall contracting strategy each year, and unless there's an

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objection, that's the way contract strategy will be rolled out.
Q. That's the body that provides the final approval?
MR. COCO: Objection.
A. It's not -- I -- I don't know of a stamp of approval, but that they are made aware of the strategy. And if there were an objection, they would make the objection.
Q. And similarly, in the spring -- in -- earlier in '06, the decision for the -- transitioning the hospital outpatient department contracts coming up for renewal in '06 was presented to the Provider Financial Strategies Work Group?
MR. COCO: Objection.
A. I don't remember a formal presentation, but the group was made aware of the strategy overall, and there was no objection to it.
MR. MANGI: This is a good time for lunch.
VIDEO OPERATOR: The time is 1:04. We're off the record.

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the conclusion that a similar system could not be implemented at BCBS in relation to services provided in treating patients in hospital outpatient departments?
A. I didn't come to the conclusion, but it was communicated to me that our system -- our computer systems could not handle that type of a methodology.
Q. Who communicated that to you?
A. I don't remember.
Q. Now, you testified earlier today that you raised this issue for the first time with Deb Devaux in late 2003, right?
A. (Witness nods.)
MR. COCO: Objection.
Q. Is that correct?
A. I raised the -- the issue of the hospital outpatient fee schedule having a lot of services falling into percent-of-charges bucket.
Q. Right.
A. And that was the -- that was my concern, that there was -- that there was a lot of payment

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going through this methodology, percent of charges.
Q. Do I understand correctly that this whole process started with you?
A. I don't know what happened before I arrived, and I don't know if it started with me. I know that when I came in to Blue Cross and saw the payment methodology for hospital outpatient, I believed that there was an awful lot falling in the percent-of-charges category.
Q. When you raised the issue with Ms. Devaux, did she tell you that someone was already working on this or had already looked at this?
A. No.
Q. Okay. Did Ms. Devaux treat it as a new suggestion or a new idea?
A. I don't know if she saw it as a new suggestion, but she -- she considered it to be a valid suggestion.
Q. And did she tell you that she would then raise it with others at the company?
A. It -- it sort of didn't go anywhere for a little while because of other competing priorities,

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and then, eventually, she felt that the time was right for me to pull together some people to look into it.
Q. Now, you said she felt the time was right for you to pull together people to look at it. Were you in charge of the Hospital Outpatient Department Fee Schedule Group?
A. It was a collaborative group, and I was partnering with my counterpart -- one of my counterparts in the actuarial department.
Q. Well, who was your -- who were you partnering with from the actuarial department?
A. Mike Marrone.
Q. Did the group have a structure? Was there -- were there people or a person who was in charge of and ultimately responsible for the group's work?
A. There was a person that was project managing the group, setting out an agenda, and pulling the people together, scheduling the meetings.
Q. Who was the project manager?
A. Terrance Driscoll.

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Q. Forgive me, but I forget, what was his title?
A. At the time he was an analyst in the finance department.
Q. Was Mr. Driscoll's work -- when you described him as a project manager, was his management role administrative, or was he substantively in charge of the work with the group?
A. It was administrative.
Q. Who was substantively in charge of the group's work?
A. Myself and Mike Marrone.
Q. What is Mr. Marrone's title?
A. I'm not sure if this is correct, but director of something in the actuarial department -- provider pricing and -- I don't know the -- he's a director of something in actuarial.
Q. At the time that you were considering these issues and the Hospital Outpatient Fee Schedule Group was doing its analysis, did you consider that Medicare was also moving to an ASP-based methodology for reimbursing drugs

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administered to patients in hospital outpatient departments?
A. We became aware of that at the end of our work and after the decision had been made to use the AWP methodology.
Q. What -- when did you become aware of that?
A. I don't know exactly. It was -- it was somewhere before the implementation in October, but after much of the work had been done to move to AWP.
Q. Sometime in the summer or fall --
A. I don't know.
Q. -- of 2003?
A. I can't -- I wouldn't want to say. I don't know. It's somewhere in -- before we actually implemented.
Q. Can you estimate how -- was this a matter of days before October, weeks, or months?
A. I would say it was several weeks.
Q. How did you become aware of CMS's plans to move to ASP for reimbursement in outpatient departments?

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A. I don't remember specifically. It could have been something I read or something someone mentioned. I don't remember specifically.
Q. Was anyone on the hospital outpatient department financial -- Hospital Outpatient Department Fee Schedule Group tasked with analyzing what Medicare was doing in relation to reimbursing for drugs administered to patients in outpatient departments?
A. No.
Q. Now, do I recall correctly you said that you may have read about it?
A. I may have seen something in a -- in a journal or heard about it from someone internally that may have -- I know I became aware of it and don't remember exactly how.
Q. What did you do after you first became aware of the fact that CMS intended to move to ASP-based reimbursement in hospital outpatient departments?
MR. COCO: Objection.
A. I didn't really do anything.

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Q. Was that issue discussed in the Hospital Outpatient Department Fee Schedule Group?
A. It was not formally discussed, because we were so far down the road of implementing the AWP and --
Q. Was there -- were there informal communications about the issue?
A. I recall someone, and I don't know who, mentioning that Medicare was changing to the ASP, and -- and I remember thinking that we were so far down the road with our analysis and our implementation, that -- that we wouldn't be considering that.
Q. Were there any reasons why BCBS of Massachusetts did not consider following suit with Medicare, other than the stage of the process?
MR. COCO: Objection.
A. I don't know. When you say, "Blue Cross," that's kind of a big --
Q. Well, I'm happy -- I'm happy to rephrase the question. Are there any reasons why you, as one of the two people in charge of the Hospital

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Outpatient Department Fee Schedule Group, did not consider further whether or not to move to ASP, other than the fact that the work of the committee was substantially along?
A. My rationale was that -- first, what you said, that we were far along in our process. And secondly, that Blue Cross -- that this was -- this was an incremental move to a new methodology and wasn't intended to cause a lot of alarm in the -- with anyone, and it was simply to move to a standard methodology. This would be the first -- this would be our first, you know, attempt to move to a standard methodology.
Q. And if you had followed Medicare in moving to an ASP-based methodology, rather than an AWP-based methodology, would that have caused alarm, to use your phrase?
A. I don't know.
MR. COCO: Objection.
Q. Well, was that a concern?
MR. COCO: Objection.
A. It was a concern that -- it wasn't a

concern about one versus the other, but using the AWP was something that was familiar with everyone, myself included, and there didn't seem to be any reason to change our direction at that point.

Q. Well, when you said earlier that -- when I had asked what were the rationales for not following Medicare, you said one of the reasons was not wanting to cause alarm. I'm trying to understand what you meant by that.

A. In my mind, AWP was -- had been around a long time and seemed to be accepted, and I didn't know what the reaction or what the -- what people thought about ASP, because it was so new.

Q. We've spoken a bit about the Provider Financial Strategy Work Group. Have you ever been a member of that group?

A. Yes.

Q. How long have you been a member of that group?

A. Since I've been an employee of Blue Cross.

Q. That's since --

A. 2003.

Q. -- 2003?

A. Yes.

Q. Has -- how many people are part of the Provider Financial Strategies Work Group?

A. Oh, I don't know for sure, but in any given meeting, there's eight to ten people.

Q. Since you've been at the company, has the membership of the Provider Financial Strategies Work Group been relatively stable?

A. There are certain core people that have been stable, and then others have joined or -- or stopped coming.

Q. Who are the core people that have been part of the Provider Financial Strategies Work Group since you joined the company in 2003?

A. Uh-huh. It's led by Deb Devaux and Rena Vertes.

Q. What is Ms. Vertes' title?

A. She's the senior vice president of the -- or she's the chief actuary, senior vice president. And so, they lead the group, and then there are representatives from finance and actuary, sales,

contracting, provider relations.

Q. Other than Ms. Devaux, Ms. Vertes, and yourself, is there anyone else who has been a member of the Provider Financial Strategies Work Group since 2003?

A. Tony Centrella, who is a vice president in the finance area, and then as people come into their roles in the organization that serve a certain function, they join the group, or when they leave the organization, they leave the group.

Q. Yeah, I understand that. I'm just trying to understand -- get a list of the people who have been there steadily since 2003. Is there anyone else you can think of who fits that description?

A. Steve Fox, I think, has been a -- he's the director of provider relations. I think he's been a consistent member of the group. There are others who are consistent members but not -- that don't attend consistently, like the sales representatives.

Q. So, you said the total membership's eight to ten people, and at least five people have been

members of that group consistently since 2003 when you first joined the company?

A. Yes.

Q. Now, I asked you earlier whether you were familiar with Blue Cross Blue Shield of Massachusetts' consideration of whether or not to move to an ASP-based methodology in the physician office setting.

A. (Witness nods.)

Q. And I believe your testimony is that you're not familiar with that.

A. Correct.

Q. Are you aware that that issue was discussed -- a subject of consideration -- at meeting or meetings of the Provider Financial Strategies Work Group?

A. I was not in attendance at that meeting, so I may have missed it.

Q. Okay. Let me show you a document.

MR. MANGI: We'll mark this as Exhibit Cizauskas 002.

("Analysis of CMS Average Wholesale Price

Reform, 2/7/04 marked Exhibit Cizauskas 002.)
Q. Have you ever seen that document before?
A. No, not that I recall.
Q. Take your time --
A. Yeah.
Q. -- and familiarize yourself with it.
A. (Witness reviews document.) No.
Q. Do you have any recollection -- does that -- does reviewing that document refresh your recollection as to having participated in any discussions with the Provider Financial Strategies Work Group assessing whether or not to move to an ASP-based methodology?
A. No, and it talks about the provider -- "Product and Provider Financial Management." I don't know if that's PFSW or not.
Q. I'll represent to you that there has been previous testimony that the PFSW was the group analyzing this.
A. Okay. Uh-huh.
Q. So, you have no recollection of --
A. I don't.

Q. -- having discussed that issue. Now, in all of the analysis that the Hospital Outpatient Fee Schedule Group performed, did it carry out any study of what hospitals and hospital outpatient departments are paying to acquire drugs?
A. I'm sorry. Say that again.
Q. Sure.
MR. MANGI: Would you mind reading that back.
(Question read back.)
A. No.
Q. Was information as to what hospitals are paying to acquire drugs at all relevant to the analysis you were involved with regarding whether or not to move to an AWP-based methodology for reimbursement?
MR. COCO: Objection.
A. No.
Q. Is the Hospital Outpatient Department Fee Schedule Group still in existence?
A. Yes.
Q. What does that group do now?

A. We are analyzing and preparing to update the outpatient fee schedule for all of the other services that fall into the percent-of-charges category and move those, as much as possible, to a standard fee schedule.
Q. What other aspects of the fee schedule are you referring to when you say aspects that are still on a percent of charge?
A. Surgeries that had not been slotted into fee schedules, some lab codes, other anesthesia, recovery room codes, and then there's new codes that hadn't been updated. It's been -- it's been a long time between updates on the fee schedule, so there's a lot of housekeeping cleanup work.
Q. Now, are you familiar with a product called BC 65?
A. Yes.
Q. And BC 65 is a managed care Medicare product, is that correct?
A. Correct.
Q. It's a product wherein Medicare pays BCBS of Massachusetts a capitated rate, and then BCBS of

Massachusetts assumes the risk in relation to members of that plan, is that a -- is that a fair statement?
A. It would be better if you asked the finance people exactly how that works, but to the best of my knowledge, that's correct.
Q. In your present position, are you involved with contracting related to the BC 65 product?
A. For the most part, it's the hospitals and negotiating the rate for the hospitals. There might be a couple of physician groups that -- most of the physician side is through a fee-for-service arrangement, and I don't deal with that.
Q. Do you know whether or not reimbursement to physicians under the BC 65 program for drugs administered to members in office is currently 95 percent of AWP?
A. I don't know.
Q. Who would know the answer to that question?
A. The finance department, I would imagine --
Q. Is there a specific individual in the

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finance department who would know the answer to that question?
A. Andreana Shanley.
Q. What is Ms. Shanley's position?
A. She's the director of actuary.
Q. Anyone else?
A. Maybe Steve Fox, director of provider relations.
Q. Anyone else?
A. I can't think of anyone else.
MR. MANGI: Let me take a quick break.
VIDEO OPERATOR: The time is 2:42. We're off the record.
(Recess was taken.)
VIDEO OPERATOR: The time is 2:53 p.m. This is Cassette 3 in the deposition of Sheila Cizauskas. We're on the record.
Q. Are there any members of the Hospital Outpatient Department Fee Schedule Group who are also members of the Provider Financial Strategies Work Group other than yourself?
A. Mike Marrone, John Killion was in and out

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of the Hospital Outpatient Fee Schedule Group, and he's also a member of Provider Financial Strategy.
Q. When the Provider Financial Strategy Work Group discussed this issue, who was tasked with presenting the findings and analysis of the provider -- of the Hospital Outpatient Department Fee Schedule Group?
A. I don't remember specifically, but I know that, as part of my presentation of the overall hospital contracting strategy, I presented that component as a bullet point in there.
Q. Let me show you another document.
(BCBSMA-AWP 12501 marked Exhibit Cizauskas 003.)
Q. Would you please review that document, Exhibit Cizauskas 003, and let me know when you're ready to proceed.
A. (Witness reviews document.) Okay.
Q. These are the minutes of a July 11, 2005 meeting of the PFSW, right?
A. Yes.
Q. And you're listed there as one of the

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attendees?
A. Yes.
Q. I'd like to draw your attention to the last bullet point under "Hospital Multi-Year Strategy."
A. Uh-huh.
Q. Does that bullet point pertain to the work of the outpatient department fee schedule group?
A. Yes.
Q. Do you see under "Action Items: Next Steps," it says, "Sheila to continue her presentation at the next meeting"?
A. Correct.
Q. Does this refresh your recollection as to how many meetings the work of the Hospital Outpatient Department Fee Schedule Group was discussed at?
A. According to my recollection, I presented the overall hospital contracting plan at this meeting, which that last bullet point was part of that, and didn't get to two pieces of the plan that I was supposed to present at a subsequent meeting,

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but I don't believe I ever did, and it -- the two pieces were unrelated to the AWP.
Q. The AWP-related components we've been talking about were all discussed and analyzed at the meeting of July 11, 2005.
A. I believe so.
Q. The third bullet point from the top --
A. Uh-huh.
Q. -- this refers to "Key changes in approach to hospital contracting." Do you see that?
A. Yes.
Q. Okay. The first one is, "We will provide the potential for the hospitals to earn reasonable cost, plus a margin with the percentage of payment that is linked to performance increasing as a portion of the total increase over the three- to four-year contract cycle."
A. Uh-huh.
Q. Now, did this pertain to inpatient -- inpatient reimbursement to hospitals?
A. This referred to the total reimbursement to the hospital.

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I'm sorry. I didn't follow your last --
A. At the hospital system, Caritas, there was an analysis done on the impact of moving to the AWP fee schedule, and it included all the products, including Medicare product.
Q. Including BC 65, for example?
A. Correct.
Q. So, the first sentence indicates that in relation to this one specific hospital system, which is Caritas Hospital system --
A. Yes.
Q. -- moving to the AWP-based methodology from the previous charge-based methodology would result in a savings of $3.9 million?
A. The difference between their percent-of-charge methodology and an AWP methodology -- Mike is saying -- was this number.
Q. Okay. And was the AWP methodology, did that come to 3.9 million less than the percent-of-charge methodology?
A. Yes, that's what it looks like he's saying.

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Q. And he says, "If we adjust for that, the commercial estimate is 3.5 million. However, this needs to be trended for one year, which would bring the commercial number back up close to 3.9." And there he's referring to how the number would change if you excluded the managed Medicare products from the analysis, is that correct?
MR. COCO: Objection.
A. I'm not sure what -- I'm not sure exactly what he's -- how he's itemizing each piece.
Q. Okay. Do you recall reviewing this e-mail when you received it in November of '05?
A. Yes.
Q. Okay. When he says, "If we adjust for that, the commercial estimate is 3.5 million," what did you understand him to be referring to?
A. I understood that the -- of the 3.9 million, 3.5 was for commercial.
Q. He then says in parentheses, "John is running some numbers this morning." Who is the "John" referred to there?
A. I'm not sure.

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Q. Would that be John Killion?
A. I doubt it. It would not have been John Killion.
Q. He then says, "This analysis, as is all of our AWP analysis, values the savings associated with the first-year implementation of the AWP reimbursement methodology." When he says, "As is all of our AWP analysis," is he referring to the other analysis performed in conjunction with the work of the Hospital Outpatient Department Fee Schedule Group?
MR. COCO: Objection.
A. I believe that's what he would have been referencing, though this is his e-mail, not mine.
Q. And then he says that they are still trying to find a solid way to estimate future savings -- or savings for future years.
A. Correct.
Q. You'll be happy to know we're not going to go through all of these. Do you know who Mary Powers is?
A. Powers? It sounds like a name I should

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know. I think she's someone that left the company, so I didn't really know her very well.
MR. MANGI: Exhbiit Cizauskas 006.
THE WITNESS: Exhibit Cizauskas 007.
(BCBSMA-AWP 000173-000175 marked Exhibit Cizauskas 007.)
Q. Now, I understand this is a document generated prior to your arrival at BCBS -- you'll see on the top left the date is 10/1/99 -- however, based on your experience at the company working on hospital contracting, do you have an understanding as to the analysis that's being performed in this document?
MR. COCO: Objection.
A. I've never seen this type of analysis.
Q. Could you take a look at the second page of the document. Have you ever seen analysis of this type?
MR. COCO: Objection.
A. I've never seen this.
Q. You'll see that under "Milton Hospital" or "South Shore Hospital" there's a column for "99

EXHIBIT 25

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
NO. 01CV12257-PBS

In re: PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION)
THIS DOCUMENT RELATES TO: ALL ACTIONS)

DEPOSITION OF ROBERT C. FARIAS, called as a witness by and on behalf of the Defendants, pursuant to the applicable provisions of the Federal Rules of Civil Procedure, before P. Jodi Ohnemus, Notary Public, Certified Shorthand Reporter, Certified Realtime Reporter, and Registered Merit Reporter, within and for the Commonwealth of Massachusetts, at the offices of Harvard Pilgrim Health Care, 93 Worcester Road, Wellesley, Massachusetts, on Wednesday, 20 October, 2004, commencing at 10:05 a.m.

to?
A. Next title was senior project manager; and I did that for about two years. That function was in the network management area -- a variety of projects related to network management that could be related to medical management, could be related to referral authorization type things; could be related to managing recontracting efforts. Just a wide variety of projects.
Q. When you say, "network," you're referring to networks of providers?
A. That's right. It was an internally-focused position.
Q. What do you mean by that?
A. Meaning that I didn't have contact with providers. I worked on projects that supported the work of network management.
Q. Okay. You held that position for about two years you said?
A. That's right.
Q. Okay. What was the next area that you moved into?

A. Next area was specifically to the contracting department in a project management role. That title was manager of planning and administration.
Q. Okay. And you moved into that position sometime around 2000, is that correct?
A. Probably about 2000, yeah.
Q. What were your responsibilities in that position?
A. In that position I was responsible for both the administrative side of managing the contracting department and the administrative side -- I mean the departmental administrative budget, the infrastructure of the department -- project management specific to the contracting department. For example, you know, when recontracting was, you know, kicking off, I would be responsible for drafting, you know, notification letters that would go out to the -- to the providers, responsible for working with legal on updating the contract templates, and also, managing the work flows related to recontracting. And again, a wide

variety of projects. You know, liaisons with other departments and so forth.
Q. The focus you said was entirely on the administrative side of managing the department?
A. Administration and planning. The planning -- it was really a split function, and it continues to be. But the planning side was related to, you know, the significant, you know, project business unit initiatives, contracting being primarily --
Q. How long did you remain in that position?
A. Actually, it was a little bit of an evolution. Probably about a year. That position evolved into my current role, director of planning and administration. When there was a reorganization, contracting became more of a broad business unit again. Network service and operations is the name of the business unit. So, my title now and following being manager of planning and administration for contracting was director of planning administration for network service and operations.
MR. MANGI: I'm sorry. Could you read

back that last answer, please.
(Answer read back.)
Q. So, your current position is director of planning and administration, right?
A. Right.
Q. And you've held that since 2001.
A. Yeah.
Q. Okay. Have your responsibilities changed from your manager of planning and administration position?
A. Yes. In addition to those responsibilities, I have reporting -- folks reporting to me, including the provider communications and training area. There's a small group of project managers and a budget coordinator which, again, they focus primarily on the infrastructure and administration side of things. In addition to that, the provider reimbursement area reports to me.
Q. What are your responsibilities in relation to that provider reimbursement area?
A. The manager of provider reimbursement

reimburse them for?
MR. NALVEN: Objection.
A. I don't know.
Q. Would others at Harvard Pilgrim be more familiar with that issue?
MR. NALVEN: Objection.
A. I couldn't answer for others.
Q. Okay. Is it fair to say that Harvard Pilgrim does not require providers to disclose their acquisition costs as part of their contracts with Harvard Pilgrim?
MR. NALVEN: Objection.
A. Within my area, we do not.
Q. Uh-huh. And indeed, Harvard Pilgrim doesn't require them to disclose their acquisition costs for drugs in any other way that you're aware of, is that correct?
A. Not that I'm aware of, no.
MR. NALVEN: Objection.
Q. Indeed, the providers' acquisition costs are not relevant to Harvard Pilgrim's calculation of the amount that it's going to reimburse them for

drugs. Is that a fair statement?
MR. NALVEN: Objection.
A. Yes.
Q. So, indeed, if providers' acquisition costs for drugs were to change, that would not alter the amount that Harvard Pilgrim is reimbursing them for drugs, is that correct?
MR. NALVEN: Objection.
A. That's correct.
Q. And indeed, if Harvard Pilgrim were to learn more information about what providers paid to acquire drugs, that would not change the amount that Harvard Pilgrim is reimbursing for drugs. Is that a fair statement?
MR. NALVEN: Objection.
A. That's a fair statement.
Q. Now, what is your involvement at present in relation to Harvard Pilgrim's contracts with physicians?
MR. NALVEN: I'm sorry. May I hear the question again, please.
(Question read back.)

MR. NALVEN: Objection.
A. I don't have direct involvement with physician contracting, other than providing the tools that the contracting consultants need as far -- you know, like the contract templates, the reimbursement strategy. That is what my --
Q. When you say, "contract consultants," what are you referring to there?
A. The staff that is responsible for directly working with the providers --
Q. And those are?
A. -- in negotiating and administering the contracts.
Q. Those are Harvard Pilgrim's employees, right?
A. That's correct.
Q. And when you refer to "reimbursement strategy," what are you talking about there?
A. The reimbursement staff reporting to me, you know, what -- how are we going to -- the physician fee schedule generally is a good example. The physician fee schedule is an RBRVS fee

schedule -- how are we going to update the fee schedule in the coming year? That's what I'm talking about.
Q. Do you have an understanding as to the criteria Harvard Pilgrim uses when deciding whether or not to contract with a provider?
A. Yes.
Q. Okay. What are those criteria?
A. Well, generally, it's -- I mean, they have to be credentialed, and they have to meet all of the credentialing standards. There has to be a need. The fact of the matter is, in our service area, our network is robust. You know what I mean? So, we're not -- it's not like a network development situation where we're going out and seeking providers.
Q. Anything else?
A. No.
Q. Okay. Since Harvard Pilgrim has one fee schedule that it applies to all providers, is it fair to say that there is no negotiation between Harvard Pilgrim and providers over the amount that

EXHIBIT 26

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS
CIVIL ACTION NO. 01CV12257-PBS

IN RE: PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION
THIS DOCUMENT RELATES TO:
ALL ACTIONS

****

CONFIDENTIAL DEPOSITION OF
EDWARD LEMKE
JANUARY 11, 2005

****

TAKEN BY DEFENDANTS
AT 500 WEST MAIN STREET
LOUISVILLE, KENTUCKY

****

THE DEPOSITION OF EDWARD LEMKE, TAKEN AT 500 WEST MAIN STREET, LOUISVILLE, KENTUCKY ON JANUARY 11, 2005; SAID DEPOSITION TAKEN PURSUANT TO NOTICE AND IN ACCORDANCE WITH THE RULES OF CIVIL PROCEDURE.

Q. So your involvement through your involvement with AWP, you understood it to be a benchmark utilized in setting reimbursement for drugs; is that correct?

MR. ST. PHILLIP: Objection to form.

THE WITNESS: It was -- the majority of the time it was used as a benchmark for measure and comparison of costs.

BY MR. MANGI:

Q. At any time prior to arrival at Humana, are you aware of any instances where any entity was acquiring drugs at a price at or even close to average wholesale price, or AWP?

A. I have no knowledge of that.

Q. Now, you arrived at Humana in 2000; is that correct?

A. Yes.

Q. What was your title at the time that you joined Humana?

A. Director of fee schedule management.

Q. What is your title today?

A. Same title.

Q. Have you held that title continuously since 2000?

A. Yes.

Q. Do you have the same responsibilities today as you did in 2000, or have they changed over time?

A. They have changed over time.

Q. What were your responsibilities when you first joined Humana?

A. Major responsibility was building a database that would be used for contract negotiation, primarily built off of comparison to Medicare fee levels.

Q. Anything else?

A. And support of contractors for Humana's Choice Care Network, which is a national PPO network.

Q. Anything else?

A. Those are the two major responsibilities.

Q. Now, how did those responsibilities changed over time?

A. The focus has changed away from the -- strictly the PPO Choice Care Network to the entire Humana national contracting.

Q. So your responsibilities have expanded, yes?

A. Yes.

Q. Do you have an understanding as to what Humana was reimbursing physicians in relation to drugs administered in the office prior to 2000?

MR. ST. PHILLIP: Objection to the form.

THE WITNESS: Only to the extent that I have access to historical information on how a fee schedule was developed or built.

BY MR. MANGI:

Q. To what extent do you have access to such historical information?

A. I have access to all of it that currently exists.

Q. How much of it currently exists?

A. If I had to make an educated guess, I would say we probably have history on 35 percent of our fee schedules prior to year 2000.

Q. If I asked you what methodology or methodologies Humana was using to reimburse physicians for drugs administered in office back to 1991, would you know the answer to that?

MR. ST. PHILLIP: Objection to form.

THE WITNESS: Intimately, only since 2000.

BY MR. MANGI:

Q. Okay. Would you know in broad terms what methodologies were used prior to 2000?

A. Only based on that history that's available to me, yes.

Q. Can you describe for me to the best of your knowledge the reimbursement methodologies that were used by Humana to reimburse physicians for drugs administered in office for the period from 1991 to 2000.

MR. ST. PHILLIP: Objection.

THE WITNESS: Of what I'm aware of, the great majority was based off of Medicare, current Medicare fees for that particular year. And for those not based on Medicare would be based on physician charges known as the HIAA fee schedules.

THE REPORTER: HIAA?

Lemke to provide an answer.
MR. MANGI: I obviously disagree with that interpretation, and the question is encompassed by other subject matters. You can answer.
THE WITNESS: I know of no analysis that exists that would indicate that being the case.
BY MR. MANGI:
Q. Now, you testified earlier that you don't know what exactly providers are paying to acquire drugs, correct?
A. Correct.
Q. All right. So it's fair to say that you have no particular expectation that there is a given relationship between the amount they paid to acquire drugs and the amount that Humana reimburses for those drugs; is that correct?
MR. ST. PHILLIP: Objection, calls for speculation.
THE WITNESS: I have no personal knowledge that -- of that.
BY MR. MANGI:
Q. And certainly, Humana has no expectation

that the amount that physicians pay to acquire drugs are 10 percent, 20 percent, 50 percent, 60 percent less than the amounts that Humana reimburses in relation to those drugs; would you agree with that statement?
MR. ST. PHILLIP: Objection, objection to form.
THE WITNESS: I have no knowledge of that.
BY MR. MANGI:
Q. And you have no expectation to that effect either; is that correct?
MR. ST. PHILLIP: Objection. Same objection.
THE WITNESS: I'm not quite sure what you mean, whether I have an expectation of that.
BY MR. MANGI:
Q. Is it Humana's expectation that the amounts that providers pay to acquire drugs are a fixed percentage less than the amount Humana reimburses in relation to those drugs?
A. The expectation that -- first of all, that it's fixed, no. The expectation that good business

practice and assuming providers that we do business with practice good business practices, is that they would only accept payment that is at or above their costs. That's my only expectation.
Q. And certainly, you have no fixed expectation as to how much higher it would be than their acquisition costs, correct?
A. Correct.
Q. And indeed, that would vary from provider to provider, depending on what they paid to acquire drugs and what Humana reimburses them for drugs?
A. Correct.
Q. The percentage could be 10 percent in one case, 50 in another, 100 in another, correct?
MR. ST. PHILLIP: Objection.
THE WITNESS: Could be.
MR. MANGI: Let's take a look at a few documents. Before that, does anyone need a break?
MR. ST. PHILLIP: It's 12:35, let's take one.
(A LUNCH BREAK WAS TAKEN.)
BY MR. MANGI:

Q. Now, Mister Lemke, when we started this morning, I had asked you about your responsibilities as director of fee schedule management, and at first, you had identified was building a database for use in contract negotiations. What's that database you were referring to there?
A. It's an extract of physician claims, provider claims from two of our major claims processing platforms that we enhance the data from the claim to include a Medicare equivalent based on geographic area and CPT or HCPCS code so that we have that data all together in one place to better analyze an individual fee schedule or an individual procedure or market all the way up.
Q. Okay. So it's a database that enables you to compare what you're paying a particular provider as opposed to what he would be getting from Medicare?
A. Correct.
Q. Is that database still in existence?
A. Yes.
Q. What does that database generate by way of

EXHIBIT 27

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

IN RE:	)	
	)	
PHARMACEUTICAL INDUSTRY	)	Civil Action No.
AVERAGE WHOLESALE PRICE	)	01CV12257-PBS
LITIGATION	)	

HIGHLY CONFIDENTIAL

DEPOSITION

of JOE SPAHN

Taken at Anthem
4361 Irwin Simpson Road
Mason, Ohio 45040
on November 30, 2004, at 9:12 a.m.
Reported by: Rhonda Lawrence, RPR/CRR

-=0=-

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JOE SPAHN
being first duly sworn, as hereinafter certified, deposes and says as follows:
EXAMINATION
BY MR. MANGI:
Q. Good morning, Mr. Spahn.
A. Good morning.
Q. As I said, my name is Adeel Mangi. I'm from the law firm of Patterson, Belknap, Webb & Tyler. We represent the defendant drug manufacturers in this case.
MR. MANGI: Before we begin, pursuant to a conversation I just had with counsel for Anthem, we're going to designate this deposition transcript and the transcripts for all Anthem witnesses we'll be taking over the next couple of days as highly confidential pursuant to the protective order. And we can revisit that as to sections as necessary in the future.
MR. THOMAS: Great.
Q. Mr. Spahn, thank you for taking the

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time to speak with us today. Have you ever been deposed before?
A. I don't believe so. I don't ever recall having, like, a court reporter. So I think the answer's no.
Q. Okay. Let me just run through some of the standard ground rules for a deposition, then.
The first is, it's important that you answer all questions verbally so that the court reporter can take down your answers. She can't take down a nod of the head or shrug of the shoulders. Okay?
A. (Indicates affirmatively.)
Q. And you'll have to answer that verbally.
MR. THOMAS: Say okay.
A. Oh. Okay.
Q. Just so she can write it down.
If at any point a question that I ask you is unclear, please stop me and tell me that, and I'll do my best to rephrase it.

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A. All right.
Q. If at any point during the deposition you'd like to take a break, please let me know, and as soon as possible, we'll take a break.
A. All right.
Q. What is your current job title, Mr. Spahn?
A. My current job title is senior health care consultant.
Q. And who's your employer?
A. Anthem Blue Cross/Blue Shield.
Q. Is your work focused on a particular region?
A. Anthem Midwest.
Q. What states fall within that area of responsibility?
A. Ohio, Kentucky and Indiana.
Q. How long have you been in this position?
A. Since 1992.
Q. And you've held the same title,

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senior health care consultant, since 1992?
A. Yes.
Q. Is that when you joined Anthem?
A. No.
Q. When did you join Anthem?
A. I joined Anthem in April of '87.
Q. We'll go through your employment history from '87 to the present in the moment.
But first, perhaps you could describe for me your educational background after high school.
A. I have a bachelor's in accounting and an MBA in finance.
Q. When did you get your bachelor's in accounting?
A. I got my bachelor's in 1972.
Q. Where did you get that qualification?
A. University of Cincinnati.
Q. And the MBA?
A. From Xavier University, in 1982.

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Q. The reimbursement is driven entirely by the fee schedule?
A. Correct.
Q. Regardless of what the specific provider's acquisition costs for those drugs may be?
A. Correct.
Q. So if, for example, Anthem were to learn that a particular provider were getting a discount or a rebate on a particular drug that lowered his acquisition costs for that drug, that wouldn't change the amount that Anthem is reimbursing that practice in relation to that drug, right?
A. No.
Q. Because the reimbursement amount is tied to the fee schedule?
A. Right.
Q. And if Anthem were to learn that providers in a region were getting a discount or rebate from a drug manufacturer in relation to a particular drug, again,

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that wouldn't change the amount Anthem reimburses because that's tied to the fee schedule?
MR. THOMAS: Asked and answered.
A. Yes. That's correct.
Q. Do you know whether Anthem's contracts with providers contain confidentiality clauses?
A. I don't know.
Q. Do you know whether or not -- are you aware of any free sample programs whereby providers can get free samples of drugs from manufacturers?
A. No, I'm not aware.
Q. That's not an area that you deal with?
A. No.
Q. Are you familiar with the major drug wholesalers operating the market today?
A. No.
Q. Do you have an understanding of what wholesalers pay to acquire drugs?

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A. No, I don't.
Q. Are you familiar with prompt pay discounts?
A. No, I'm not.
Q. You've never heard that term?
A. No, I haven't.
Q. To the best of your knowledge, do you know of any instances where providers have conspired with drug manufacturers to inflate the average wholesale prices for drugs?
A. No.
Q. Are you aware of any instances where pharmacies or pharmacy benefits managers have conspired with any drug manufacturers to inflate any drug's average wholesale prices?
A. No.
MR. MATT: Objection. No foundation.
MR. THOMAS: I was just going to let it go.

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Q. Do you know whether Anthem has been involved in any litigations pertaining to average wholesale prices for drugs other than this one here today?
A. No.
MR. THOMAS: Objection. Foundation.
Q. Do you know of any other litigations that Anthem has been involved in relating to reimbursements to providers for drugs administered in office?
A. No.
MR. THOMAS: Same objection.
MR. MANGI: Let's take another quick break and then we'll look at some documents.
(Recess taken.)
BY MR. MANGI:
Q. Prior to the break, we were talking about providers' acquisition costs and the fact they're not relevant to Anthem's reimbursement amounts. Do you recall that testimony?
A. Yes.

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Q. Okay. And part of that was that Anthem has no information about what the providers' acquisition costs are, right?
A. Correct.
Q. So it's fair to say that Anthem has no particular expectation that providers' costs would be, you know, 10 percent, 30 percent, 50 percent, something more, something less than the amount they're reimbursed in relation to those drugs, right?
MR. THOMAS: Object to form.
A. Yes.
Q. I'd like to just plug a couple of gaps here.
Do you know how many states Anthem operates in nationwide?
A. Gosh. I think it's nine.
Q. Do you know how many regions that's divided into? One is the Midwest that we've been discussing.
A. You have Mideast, you have Midwest,

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you have West, and you have South, Southeast. I think Virginia's called the Southeastern region.
MR. THOMAS: It's just East. It's not Mideast.
A. Did I say Mideast? Sorry. East, West, Midwest and Southeast.
Q. So a total of four regions?
A. Four regions.
Q. Do you have an understanding as to whether or not Anthem reimburses providers that are not part of its network if an individual insured is treated by that physician?
A. I'm sorry. Could you repeat that?
Q. Sure. You understand that Anthem has contracts with providers, correct?
A. Correct.
Q. And you understand that Anthem's insureds primarily are treated by those providers?
A. Correct.

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Q. Now, if an Anthem insured visits a doctor that is not part of Anthem's network and is administered a drug by that doctor, do you have an understanding as to whether or not Anthem will reimburse that doctor in relation to that drug?
A. Do I have an understanding?
Q. Right.
A. Yes.
Q. What are the terms of that reimbursement?
A. Well, we wouldn't. If they're non-par, we wouldn't reimburse.
Q. I'm sorry?
A. If they're not par, non-participating, if they're noncontracted, then we don't -- we wouldn't reimburse them. We'd reimburse the member.
Q. So in that instance, the individual member would pay the physician's full bill and then seek reimbursement from Anthem?
MR. THOMAS: I'm going to object on

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foundation. We're not talking about any specific product here. It may vary depending upon product.
Q. Sure. Let's clarify that.
Do you have an understanding as to whether reimbursement for out-of-network-provider visits varies from plan to plan or product to product?
A. No. It's the same.
Q. Okay. Now, in those instances, will Anthem reimburse anyone in relation to that office visit?
A. We would repay our fee schedule amount to the member.
Q. So the responsibility for making payments to the physician would rest entirely on the member; is that correct?
A. Correct.
Q. And the member would then seek reimbursement from Anthem?
A. Correct.
Q. And in that instance, when we're

EXHIBIT 28

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

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In re: PHARMACEUTICAL :MDL DOCKET NO.

INDUSTRY AVERAGE WHOLESALE :CIVIL ACTION

PRICE LITIGATION :01CV12257-PBS

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Tuesday, November 23, 2004

Washington, D.C.

HIGHLY CONFIDENTIAL

Deposition of KELLY ELLSTON, commencing at 9:59 a.m., held at the offices of Morgan, Lewis & Bockius, 1111 Pennsylvania Avenue, N.W., Washington, D.C., before Keith Wilkerson, a notary public in and for the District of Columbia.

A. That's correct.
Q. In 2001 did you move to a different job?
A. Yes. I moved to Union Labor Life.
MR. KLEIN: Can you repeat that?
THE WITNESS: I moved to Union Labor Life Insurance Company.
MR. KLEIN: Thank you.
BY MR. MANGI:
Q. And that's where you're still employed. Correct?
A. That's correct.
Q. Have you been continuously employed by Union Labor Life since 2001?
A. That's correct.
Q. What position did you come to at Union Labor Life?
A. The assistant vice president for claims and care management.
Q. How long did you remain in that position?
A. I'm still in that position.
Q. So your title is currently assistant VP for claims and care management?

A. That's right.
Q. Who do you report to?
A. The VP of insurance operations.
Q. And who is that?
A. Jim Tillotson.
Q. Now, are you familiar with ULLICO?
A. Yes.
Q. Is ULLICO the same thing as Union Labor Life Insurance Company or is it a subsidiary?
A. Union Labor Life Insurance Company is a subsidiary of ULLICO, I believe, Inc.
Q. And you work for the subsidiary, Union Labor Life Insurance Company?
A. I believe so. I'm not trying to hedge that one. It's just our family of companies is a little bit complicated. I believe my employer is Union Labor Life.
Q. Now, just to get our terminology straight, does ULLICO stand for Union Labor Life Insurance Company also?
A. Union Labor Life Insurance Company is an entity. ULLICO is an overarching entity that

includes other product lines and other divisions, so it may somewhat stand for it, but they're two different things.
Q. For purposes of today's deposition, when I'm referring to the parent company, I'll call it ULLICO, and when I'm referring to the subsidiary I'll refer to Union Labor Life.
A. That's how we do it generally.
Q. Now, are you familiar with Zenith Administrators?
A. Yes, I am.
Q. What is Zenith Administrators?
A. Zenith Administrators is a third party administrator that is owned by ULLICO, Inc. It provides administrative services to Taft-Hartley trust funds and health and welfare funds.
Q. Other than both being subsidiaries of ULLICO, is there a relationship between Zenith Administrators and Union Labor Life?
A. To the extent that Zenith Administrators actually provides claims payment services for some of our insured business.

Q. Does Zenith function purely as a claims processing entity?
A. Not that I understand. They also provide eligibility administration and pension administration, I believe. I'm not fully familiar with all the product lines they deliver.
Q. Now, are you familiar with USA Health Services?
A. I believe that was a company that was around a long time ago, but not really.
Q. Do you know what if any the relationship is between Union Labor Life and USA Health Services?
A. No.
Q. How about between USA Life and Zenith Administrators?
A. No.
Q. At the position you've held at Union Labor Life since 2001, what were your responsibilities as assistant VP of claims and care management?
A. I was initially responsible for running a service center and multiple claim offices for Union

$5,000 for an immunization which is beyond anything that would be expected, say 10 percent you'd be paying, that would be something we would investigate to say what would be reasonable and acceptable.

So in those instances, if there is an outlier that doesn't make sense, we would research it, and it's possible. We probably would not understand what they paid for it, but we would definitely benchmark it against what should be acceptable.

BY MR. MANGI:

Q. So if a particular physician were to bill an extraordinary sum in relation to an immunization, then that may form the basis for an investigation. Correct?

A. It would be a flag, just like we have flags for fraud and abuse and we have reviews for different dollar amounts. There are many steps in the claims process that look to making sure that things make sense.

Q. It would be a flag of some sort of overbilling.

A. Yes.

Q. And the basis for that flag would be a comparison to the amount that Union Labor Life would ordinarily pay in relation to a similar immunization. Is that correct?

A. Or what would be, again possibly using our pharmacy team, what would be the expected amount that should be reimbursed.

Q. Does Union Labor Life have a particular benchmark of what are common reimbursement amounts for all drugs?

A. I don't know. That would be in the pharmacy area, whatever tools or methods they use to get information.

Q. Well, in relation to paying claims to physicians in relation to drugs that are not immunizations, other injectable and infusible drugs, how will Union Labor Life determine whether or not the amount that it's paying is subject to a flag or not subject to a flag?

A. For the most part it is by the amount. We have thresholds of review, and it's not just

specific to a drug. We have thresholds of review for a provider claim over a thousand dollars for office visits, hospital claims over 5,000, 10,000, 25,000. So we have different points at which there's a review just to make sure that things are adding up.

Q. Now, leaving aside those specific instances where there's a suspicion that a physician, a particular physician is overbilling or there's some other concern about fraud or something like that, leaving those instances aside, if Union Labor Life were to gain more information generally about what physicians in the market are paying to acquire drugs, that wouldn't change the amount they would pay as reimbursement. Correct?

MR. MCGLONE: Same objection.

THE WITNESS: In our current structure, because we are guided and utilizing the PPO contracts, it would not, because that's part of the negotiation that the PPO and the provider have.

BY MR. MANGI:

Q. And indeed, Union Labor Life is not involved in that negotiation process.

A. That's correct, between the PPO and the provider.

Q. Now, based on the fact that Union Labor Life does not know what physicians' acquisition costs are, is it fair to say that Union Labor Life does not know how much money physicians are or are not making in relation to drugs they administer in office?

A. That's correct.

Q. Union Labor Life does not know how much of a loss they're taking or how much of a profit they're making?

A. That's correct.

Q. And it would be fair to say that Union Labor Life certainly does not have a particular percentage expectation of the amount of profit that a physician may be making. Correct?

A. No.

Q. It would be impossible to say that Union Labor Life expects that they'll make a percentage profit of 5 percent, 10 percent, 20 percent, 30 percent, 40 percent?

A. That's not in our calculations.

Q. That's something that is entirely irrelevant to Union Labor Life's calculations of the amounts that it's going to reimburse. Is that correct?

A. Correct.

Q. Now, we spoke about instances where billing is a percentage of charges.

A. Yes.

Q. I just want to be clear here. Do physicians bill based on a fee schedule or on a percentage of bill charges or either?

A. It could be either.

Q. Do you have any knowledge as to how physicians would arrive at the amounts billed when they're not using a fee schedule?

A. Well, generally the physician doesn't derive what they bill based on percentage of savings or fee schedules. To my knowledge, the physician's billing is completely up to how they decide to set their prices. It's how they're reimbursed is the percentage of savings or the fee schedule. Billing, they can charge what they charge.

MR. MANGI: Nothing further. Do you have any questions, Alan?

MR. KLEIN: I do have a couple of questions.

EXAMINATION BY COUNSEL FOR PLAINTIFFS

BY MR. KLEIN:

Q. My first question is: To what degree were you involved in the negotiation between Union Labor Life and the PPOs?

A. I was not.

Q. And to what degree do you know what factors those that did negotiate on behalf of Union Labor Life, what factors they considered in negotiating with the PPOs?

A. My understanding is when we have proposals or we are looking at new PPOs we have a team of -- a multi-disciplinary team, that goes over the process. And in that team, discussions of the codes for amount, CPT codes that are looked at, access fees that are derived, and scope and responsibility of the contracts are discussed.

Q. And have you ever taken part in these

discussions?

A. Yes.

Q. And do you normally take part in these discussions?

A. Yes.

MR. KLEIN: I have no further questions.

MR. MCGLONE: I have a request to make that we record on the record what I think is an understanding, and if not, I hope it will be one, that the deposition transcript will be designated highly confidential pursuant to the protective order in place in this case.

MR. MANGI: We have no objection to that. Alan, I trust you have no objection to that.

MR. KLEIN: I have no objection.

EXAMINATION BY COUNSEL FOR JOHNSON & JOHNSON

BY MR. MANGI:

Q. Just a quick bit of follow-up. In relation to the factors that are considered in deciding whether or not to enter into a contract with a PPO which you were just questioned about, is it fair to say that the amount of profit or loss that

physicians in a particular network will make when reimbursed for drugs in office is not one of the factors that's considered by Union Labor Life?

A. I would say that's correct. Our factor is what will it cost us to provide health care services to our membership or our clients at a more macro level.

Q. And in that regard, Union Labor Life is always looking, based on a competitive dynamic, to get the best and most price efficient deal that it can. Correct?

A. That's correct.

Q. And as we discussed before, Union Labor Life has no expectation of what sort of profit physicians may be making in relation to drugs administered in office, be it 20 percent, 30 percent, 40 percent, or something more than that.

A. We don't get to that level of granularity, and we're looking at the overall cost of health care.

Q. That's something that's irrelevant to Union Labor Life's determination of the amounts that

EXHIBIT 29

IN THE UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

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In re: PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION,	)	No. 01-2257-PBS
THIS DOCUMENT RELATES TO ALL ACTIONS,	)	

HIGHLY CONFIDENTIAL

PURSUANT TO PROTECTIVE ORDER

TELEPHONIC DEPOSITION OF SCOTT WERT

WEDNESDAY, FEBRUARY 1, 2006

Telephonic deposition of SCOTT WERT, taken on behalf of Johnson & Johnson, 10834 International Drive, Suite 200, Rancho Cordova, California, at 10:00 a.m., on Wednesday, February 1, 2006, before RICHARD M. RAKER, CSR No. 3445, Certified Shorthand Reporter.

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name is Adeel Mangi, as you've just heard. I represent Johnson & Johnson in this litigation. We are doing this deposition by phone today, so I'd ask that any questions I ask that are unclear because of problems with the transmission, please let me know and I'll repeat them. Okay?
A. Okay.
Q. Similarly, if any questions I ask are unclear to you substantively, please let me know, and I'll do my best to rephrase it.
A. Okay.
Q. I didn't get your answer to the last question, Mr. Wert.
A. "Okay."
Q. And now's a good time to mention, since we're on a phone deposition, it's especially important to answer questions verbally, both so I hear it and the reporter can take it down.
A. Sure.
Q. Are you currently employed, Mr. Wert?
A. Yes.
Q. Who is your employer?

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A. Health Net Pharmaceutical Services.
Q. What is your title at present?
A. Vice president trade relations.
Q. How long have you held that position?
A. Since November of 2001. So that would be a little more than four years.
Q. How long have you been employed at Health Net Pharmaceutical Services?
A. I'm just trying to think. It's a little bit difficult to answer because I started working for a company that ended up merging with Health Net and Health Net Pharmaceutical Services.
Q. Let's come to it another way.
A. Okay.
Q. Can you describe to me your education after high school, please.
A. I have a degree -- a BA degree in psychology from Franklin & Marshall College in 1982. I have a Pharm.D from the University of Arizona in 1993. I have a pharmacy practice residency completed at the VA Hospital in Tucson, Arizona, in 1994.

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Q. Between -- in what -- did you complete the bachelor's degree in 1982?
A. Yes.
Q. Were you employed between 1982 and '93?
A. I was a military officer from December of 1982 through August of 1987.
Q. Did your role in the military involve health insurance or the provision of healthcare services of drugs in any way?
A. No.
Q. What did you do after you left the military in 1987?
A. I enrolled at the University of Arizona.
Q. That was in your Pharm.D program, correct?
A. Correct.
Q. You were a full-time student until you completed that degree in '93?
A. That's correct.
Q. Did you then immediately start the residency at the VA Hospital that you completed in '94?
A. Correct.

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Q. In the course of that residency, did you have any role in relation to the acquisition or purchase of drugs?
A. No.
Q. What did you do after completing that residency?
A. I joined -- I was hired by Intergroup Healthcare Corporation, a managed care organization located at the time in Tucson, Arizona. I was hired as a clinical pharmacist.
Q. How long were you with Intergroup?
A. It was six months, and then the company merged with Foundation Health and subsequently Foundation Health became Health Net. So I essentially spent my entire career within Health Net.
Q. As a clinical pharmacist starting with Intergroup -- how long did you hold that position, by the way, clinical pharmacist?
A. Six months.
Q. What were your responsibilities in that position?

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BY MR. MANGI:
Q. Well, let me ask it another way. You're aware that wholesalers will purchase drugs at WAC or an amount below WAC depending on the rebates and discounts that they get, correct?
A. Yes.
Q. You're also aware that WAC is a different number from AWP, correct?
A. Correct.
Q. Indeed, the AWP will generally be either 20, 25 or 30 percent over the WAC for a drug, right?
A. Right.
Q. It's certainly fair to say that wholesalers and other entities in the market are not actually purchasing drugs at AWP; they're purchasing at WAC or something below WAC, right?
MR. WILLIAMS: Calls for speculation.
MR. SELFRIDGE: Also lack of foundation.
BY MR. MANGI:
Q. You can answer.
A. Generally, yes.
Q. Indeed, you're not personally aware of any

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single entity that purchases at AWP, correct?
MR. WILLIAMS: Lack of foundation.
THE WITNESS: Am I aware? I'm not aware.
BY MR. MANGI:
Q. Okay. Now, we've discussed a couple of different things. We've discussed WAC, and we've discussed the fact that the price at which entities in the market acquire drugs will be a percentage below WAC that varies depending on the amount of the rebate or discount that entity gets on that drug, right?
A. Right.
Q. We've discussed AWP, which is a benchmark that is either 20 or 25, sometimes 30 percent above the WAC for given drugs, right?
A. Right.
Q. So it's fair to say, isn't it, that the relationship between any individual entity's acquisition cost for drugs and the AWP for that drug will vary depending on the amount of rebates or discounts that that entity is getting, right?
A. Right.

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Q. Indeed, there will be no settled percentage differential between the two of those numbers, the actual acquisition costs on the one hand and the AWP for that drug on the other, right?
A. Right.
Q. Will vary from entity to entity, drug to drug depending on the leverage that those entities have and their ability to exact differential rebate and discounts from drug manufacturers, right?
A. Yes.
Q. And certainly Health Net has no fixed expectation or has no expectation that there is, in fact, a fixed relationship between actual acquisition and AWP, correct?
MR. WILLIAMS: Objection; lack of foundation.
THE WITNESS: Correct.
BY MR. MANGI:
Q. In other words, Health Net recognizes that the relationship between the actual acquisition cost for a drug and the AWP for a drug will vary widely depending on the amounts of rebates or discounts

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that the purchasing entity can get from the manufacturer.
A. Right.
Q. So certainly, if one were to say that, well, you know Health Net expects that there will be a fixed relationship of, say, 20 percent or 30 percent or 40 percent, there would be absolutely no foundation for that, correct?
A. Correct.
Q. That would be simply an inaccurate assumption that lacks any foundation whatsoever, right?
MR. WILLIAMS: I'll object as ambiguous. Also calls for speculation.
MR. SELFRIDGE: It's an argumentative question, but you can answer.
THE WITNESS: Yes.
BY MR. MANGI:
Q. Now, let's talk for a moment about generic drugs. Actually, withdraw that.
Do you know at what rate Health Net can't reimburse doctors for drugs that they administer to

EXHIBIT 30

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

IN RE PHARMACEUTICAL	)	
INDUSTRY AVERAGE WHOLESALE	)	MDL No. 1456
PRICE LITIGATION	)	Civil Action: 01-CV-12257-PBS
THIS DOCUMENT RELATES TO	)	
ALL CLASS ACTIONS	)	

Deposition of MIKE BEADERSTADT, taken before GREG S. WEILAND, CSR, RMR, CRR, Notary Public, pursuant to the Federal Rules of Civil Procedure for the United States District Court pertaining to the taking of depositions, at Suite 300, 1630 Fifth Avenue, in the City of Moline, Illinois, commencing at 9:07 o'clock a.m., on the 17th day of September, 2004.

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that process.
Q. Okay. I want to shift over now to talk about the pharmacy side. Should we switch over to Carol? Is that the best thing to do?
A. Probably. She will have all the information I have and more.
MR. HAAS: Okay.
MS. MacMENAMIN: Will Mr. Beaderstadt be available for questioning later on, or is he leaving?
MR. HAAS: No, he's sitting here. We will come back to him with some top-level questions.
MS. MacMENAMIN: Sounds good.
(Whereupon, an off-the-record discussion was held.)
BY MR. HAAS:
Q. Okay. One follow-up question for Mike. With respect to the transition from AWP to AWP -- 87 percent of AWP that we discussed earlier, without going back to the documents, is it correct that that project first began in the fall of 2001?
A. Yes.

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Q. Aside from the contracts with Caremark and McKesson that we have discussed, did John Deere have any other contracts with specialty pharmacies or specialty supply houses or PBMs for the supply of drugs?
A. For me? Yes. We had several different home health agencies, others who would be dispensing those types of drugs, some of them national. Not all of the names will come to me.
Q. Was the relationship with those specialty providers similar to that of McKesson in that John Deere would reimburse the specialty provider for drugs provided on an as-needed basis to the physician?
A. Yes.
Q. Do you have an idea of when the particular time frame that those specialty pharmacies and specialty providers entered into these relationships with John Deere?
A. My recollection is that they may have been entered into for some time. It was though probably late in '99 or somewhere in '99 when we first

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started insisting that they be sourced from that supplier.
Q. So prior to 1999, doctors had the option of utilizing that alternative to the buy-and-bill methodology, and it was starting in 1999 that John Deere required that?
A. Yes, approximately '99.
MR. HAAS: Okay. I have no further questions.
MS. MacMENAMIN: I actually have some follow-up questions for Mr. Beaderstadt. I didn't know you were going to go straight there. And one follow-up question for Carol, for Ms. Sidwell.
(Whereupon, an off-the-record discussion was held.)
EXAMINATION
BY MS. MacMENAMIN:
Q. All right. Mr. Beaderstadt, can I ask you generally, what is your understanding of the term average wholesale price?
A. Generally my understanding is that it's a benchmark that we use to price specific drugs in the

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physician's office and the pharmacies.
Q. Do you understand it to have a relationship to any actual acquisition cost?
A. I don't believe it has any relationship that is a consistent relationship.
Q. Are you aware of who establishes or sets AWP?
A. I don't know exactly how it's established. I know that we get different numbers from a variety of sources.
Q. In your time at John Deere, was it ever your responsibility or your role to negotiate pharmacy reimbursement contracts?
A. Indirectly in my oversight of Carol's role.
Q. Was it ever your role to negotiate rebates or discounts with drug manufacturers?
A. Once again, indirectly.
Q. Was it ever your role or responsibility to negotiate contracts with PBMs?
A. No.
Q. In your oversight of the pharmacy and